Van de Warker, (E.)

WITH THE AUTHOR'S COMPLIMENTS.

A YEAR'S WORK

IN THE

CENTRAL NEW YORK

HOSPITAL FOR WOMEN.

BY

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A YEAR'S WORK IN THE CENTRAL NEW YORK HOSPITAL FOR WOMEN.

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The following report of the hospital is presented, not alone for the interest that nearly always attends operative gynecology, but for the reason that the reports of special hospitals, large and small, are valuable as an exposition of work done under common conditions and therefore valuable as a basis for comparison; but it is of further interest as illustrating some peculiarities of practice, which viewed in connection with the results, are of value as an attempt to give precision to methods concerning which there are differences of opinion. It is with reference to this latter point of view that the following cases are analyzed.

The class of cases to which the most common interest attaches is that of laceration of the cervix uteri. It is also in relation to this group that the practice of the operator differs most widely from that of the originator of the operation for its repair as well as that of the majority of those who have followed his example. Many years have passed since I expressed the opinion that the inveterate catarrh which is such a universal attendant of cervical rents is an outcome of the injury, and can only be removed permanently by repair. It is true that by long continued applications of alteratives and local stimulants and vaginal irrigations the glandular hypertrophy and the erosion may be abated to such an extent that for a time the catarrh and its attending condition will be relieved. If this were the end of it no possible objection could be raised against it. But my experience, both in my own cases and those which I have seen from the practice of others, has taught me that such a result is rarely reached.

There exists in every cervix injured to a surgical extent, an inexhaustible source of irritation that can not be removed without repair. The series of cases operated on in the hospital will be first studied with reference to the extent and rapidity with which the catarrhal condition was relieved. This can be measured with great certainty for the reason that nothing except repair was undertaken for its cure. Our experiment then is uncomplicated by anything that will vitiate the results. The cases are studied to better advantage in a tabular statement than any other.

In the following table the laceration is regarded as the initial lesion, and the degree by the number of sutures necessary to complete the repair. This seems to be the only method of securing a comparative measure of the injury. I do not wish to be understood, however, as claiming that the extent of secondary lesion is in any degree dependent on the extent of the rent. That we know is to no extent true. What I do wish to prove by it is, that the primary lesion was of such an extent as to imperatively demand repair as a method of treatment. This, in view of the loose manner in which the operation is resorted to, seems to be, in connection with the purpose to which I apply it, a very proper precaution. The extent o which the glandular and secretory lesion was corrected will be measured by the extent to which, after the operation, the more active evidences were removed, and it must be understood without other treatment as a rule. This, to my mind, seems to be as fair an estimate of value as can be given to such an uncertain quantity. Granting these conditions, we will now examine the table:

TABLE I.—TRACHELORRHAPHY AS A CURE FOR CERVICAL CATARRH.

NO.	NO. OF SUTURES.		CONDITION OF UTERUS AND FLAPS.	DURATION OF INJURY: YEARS.	RESULTS.
	R.	L.			
1	2	3	Erosion, eversion, hypertrophy and induration, catarrh not marked.	8	Unknown.
2	3	3	Eversion, catarrh profuse.	3	Catarrh cured.
3	0	3	Hypertrophy, induration, catarrh not profuse.	5	Induration relieved; catarrh a trace.
4	3	2	Retroversion, hypertrophy, fixation.	10	Hypertrophy reduced, catarrh cured, mobility improved.
5	3	3	Eversion, erosion, catarrh profuse.	2	Catarrh a trace, gain in nutrition.
6	3	4	Retroversion, erosion, eversion, catarrh profuse.	6	Catarrh reduced to a trace.
7	1	3	Erosion, catarrh slight.	4	Condition unchanged.
8	3	3	Retroverted, hypertrophied, catarrh profuse.	3	Catarrh reduced to a trace.
9	2	3	Hypertrophied, indurated, catarrh slight.	5	Hypertrophy reduced. Catarrh a trace. Subjective symptoms unchanged 6 mo. after.
10	2	2	Erosion, catarrh profuse.	1	Catarrh nearly nil.
*11	2	1	Hypertrophy, metorrhagia, retroversion, erosion, catarrh.	3	Hypertrophy reduced, metrorrhagia cured, catarrh a trace.
12	3	3	Catarrh, erosion.	1½	Catarrh unchanged.
13	3	3	Eversion, erosion, profuse catarrh, metrorrhagia.	2	Hem. cured, catarrh a trace.
14	3	2	Hypertrophy, catarrh not profuse.	3	Hypertrophy reduced, catarrh unchanged.
15	0	3	Catarrh, erosion.	4	Catarrh lessened.
16	3	2	Induration, hypertrophy, uterine fixation, menorrhagia, catarrh not profuse.	8	Menorrhagia cured, induration and hypertrophy greatly reduced, in 3 months uterine mobility restored.
17			Erosion, retroversion, hypertrophy, catarrh profuse.	5	3 sutures posterior. Catarrh cured.
18	1	3	Fixation, hypertrophy, induration, catarrh not severe.	3	Slow amendment.
19	3	3	Retroversion, erosion, catarrh.	2	Results not known.
20	2	2	Erosion, catarrh.	3	Catarrh cured.
21		3	Erosion, catarrh.	1	Catarrh a trace.
22	1	3	Erosion, catarrh.	4	No improvement while in hospital.
23	2	3	Hypertrophy, retroversion, erosion, eversion.	10	Hypertrophy reduced, great improvement in nutrition and reflex symptoms.
24	3	2	Fixation, hypertrophy, induration.	9	Hypertrophy and induration reduced, mobility nearly restored before leaving hospital by pelvic massage.
25	2	2	Retroversion, erosion, catarrh.	3	Catarrh cured.
26	3	3	Erosion, catarrh profuse.	6	No note made of results.
27	2	3	Hypertrophy, erosion, catarrh.	5	Catarrh cured.

*In No. 11, two sutures were posterior and one left lateral.

It will be observed that several of the cases were complicated by uterine fixation, the result of antecedent pelvic peri-uterine inflammation. This complication is so generally regarded as a contra-indication for the operation that it requires a separate analysis.

The following conditions would, in my opinion, render trachelorrhaphy safe in the presence of uterine adhesions. In the first place they must be chronic in the most ample meaning of the word. Of equal importance is the absence of high temperature as a long and interrupted part of the history. Pelvic abscess ought, if a feature of the case, to be a remote event. There ought also to be an absence of circumscribed indurations or phlegmas. The natural tendency of adhesions, the result of pelvic peritonitis, is to be absorbed. If there be no relapses or retarding forces present in the pelvis to prevent absorption, uterine mobility should be restored in from six months to two years, roughly stated. As a matter of fact we will meet with those cases in which uterine fixation and pelvic tenderness have persisted for many years. It has been my experience to find these associated with cervical rents. The philosophy of the non-absorption is a simple one. We have in the laceration of the cervix a focus of irritation that invites a constant state of pelvic hyperæmia that retards or arrests the vital act of absorption. The results that have followed in the few cases in which I have ignored the universally regarded law of non-interference have justified both my practice and the theory upon which it was based. One of the cases was for nearly two years under my care, and was afterward for eight months in the Woman's Hospital in New York, during which time she was under most active treatment to reduce the adhesions preparatory to a repair of the cervix. She returned at last under my care. I repaired the cervix after considerable hesitation, and at once the pelvic tenderness abated, normal circulation was restored, and the adhesions gradually disappeared. In two months after the operation the woman walked for the first time in over three years. My method of operating may have something to do with the absence of relapsing inflammation following the operation. The operation is done without drawing the uterus down by the use of my needle forceps; in any case, of course, no traction can be made upon the organ when it is situated high and restrained by adhesions, and here the needle for-

ceps is perfectly adapted to the condition. I regard this simply as a preliminary report upon the subject, and shall continue to work upon it as suitable cases present themselves.

TABLE II.—TRACHELORRHAPHY IN UTERINE FIXATION.

NO.	DURATION OF ADHESIONS. YEARS.	HISTORY.	OTHER TREATMENT.	RESULTS.
1	4	Pelvic peritonitis. Two relapses. Retro-uterine adhesions.	Irrigation, pelvic massage, ammo.muriate., pot.chloride.	Pelvic tenderness subdued. Rapid disappearance of adhesions.
2	2	Great pelvic tenderness. Impaired locomotion.	Before operation: irrigation; after, massage, irrigation.	Able to walk and stand before leaving hospital in six weeks.
3	Not known.	P. peritonitis followed by abortion; has had chronic diarrhœa, thickening of vag. vault, not evident above pelvis.	Irrigation; after op. pelvic massage, galvanism.	In three months uterine mobility restored.
4	1	Relapses, retro-uterine adhesions, vag. and ut. hypersensitive.	Irrigation.	Pelvic hyperæmia reduced. Improved mobility.

Our perineal operations have been a subject of great interest to us. It is not very many years ago since I regarded an operation for the restoration of the sphincter ani with great dread. Success was such an uncertain quantity. A failure now would be a great surprise to us. I do not think this has been the result of any "new method." Every gynecologist has such a method in perimorrhophy. We make a flap operation in both the complete and incomplete forms of the injury. A good idea of the orginal form of the flap may be had from Hart & Barbour, *fig. 324*. The flap is not divided at *b* as it is figured, but is left continuous. The sutures are passed from the anal margin upward; and, when the flap is reached the needle is worked through the flap which is thus included. A sufficient number of sutures are thus passed. When the wound is closed the vaginal surface is roofed over, and is sealed against infection from this source as well as from urine. We use a larger number of sutures than is generally directed in the text-books. If there is a rectocele the flap is carried up sufficiently high on the vaginal wall to bring it down. In such cases there may be a redundancy of flap when the wound is closed, which is removed.

Dr. Trenholm, of Montreal, lays claim to this operation as original. This is absurd, as the idea is an old one. No one at this late

day would make such a claim except one who has a morbid inclination to "priority." When the sphincter is torn a line of close sutures is placed in the rectum and the sutures through the muscle are passed after Emmet's method. Now comes the chief factor of success. It is a process that is abandoned by most gynecologists, and condemned in the text-books. In operations for repair of the sphincter a counter incision is made through the muscles directly backward, and the internal sphincter is stretched.* A clean cut at a right angle to the line of fibers is sure to heal, and as all strain is taken off the ends of the newly joined muscle they are equally sure to unite. Another advantage is, that there is no accumulation of rectal gas, and no impaction takes place. In incomplete perineorrhophy the sphincter is paralyzed by stretching. Complete rest is thus given to the perineal region. In the latter case the bowels are encouraged to gentle movements daily. If this counter cut is made, it matters little how the sutures are passed or of what material they are made, union between the torn ends of the sphincter muscle is nearly certain, for the simple reason there is no force to pull them asunder. It is a mystery to me why any one should oppose the method.

The first case was a serious and complicated one. In the first place the woman was exceedingly fat, always a troublesome complication in a gynecological operation, and she had been through two previous unsuccessful operations, causing the loss of much valuable tissue. The laceration was complete through the external sphincter; about half an inch above was a recto-vaginal fistula, about three-eighths of an inch in diameter, and covering all from view was a large rectocele. The first step in the operation was to make the counter cut directly backward. This freed the ends of the torn muscle so that they could be easily approximated. The flap was next dissected up laterally, and over the fistula and into the rectocele. The fistula was closed by a line of fine cat-gut sutures, cut short and covered over when the large flap furnished by the rectocele was brought down. The remaining steps of the operation were completed as already detailed. The result was perfect.

Four other cases of complete rupture of the perineum were treated

* The idea was borrowed from Salmon. He called it his "back cut," and was very successful in fistulæ in ano.

successfully in the hospital for the year. Five cases of incomplete rupture, all associated with laceration of the cervix uteri. Instead of closing the cervical rent in one case the cervix was so greatly elongated with pendulous flats that a circular amputation was made; posterior colporrhaphy was then made, followed by perineorrhaphy. Union was perfect at the seat of each operation.

It is interesting to note that in making double repair operations the only instances of hemorrhage that were observed by us took place. In one the hemorrhage, which occurred on the third day, was checked by iron injection, and in the second the bleeding was more obstinate, repeated astringent irrigations failed, and as it was a week after the operation I thought it better to pack the vagina than to take the work down. Union was complete.

Four cases of intra-uterine growths were treated. Of these three were mucous polypi, and one intra-uterine fibroid. The latter only deserves notice. The subject gave the usual history of menorrhagia, and its removal was urgently demanded. The tumor was the size of a hen's egg, and the cervix was rapidly dilated to a diameter to permit easy removal by dilators after the patient was upon the table. It was done with great ease and but little loss of time. For small intra-uterine growths I do not believe it is necessary to employ any other than rapid dilatation. The use of tents is unsafe and is, I believe, being abandoned, while a method of gradual dilatation by plugs of cotton, which I have noticed going the rounds of the medical journals, is filthy and slow. For digital exploration for several years I have resorted to rapid dilatation, and the method has given perfect satisfaction, and I would advise it in all cases to the exclusion of tents.

The cases of malignant disease of the cervix uteri were unfortunate. The opening of the hospital was a week in advance of its formal opening to admit a case of epithelioma of the cervix in a woman forty-eight years of age, who a year before had undergone the removal of a large mass from the cervix. It had quickly reformed. For many weeks previous to admission she gave a history of high temperature and repeated hemorrhages. The house was filled with a vile odor directly she was received, the absorption of the fetid discharges evidently causing the fever. The mass was removed

and the cervix amputated high up. She was securely packed and put to bed in a very low condition. About an hour after she was reported as bleeding. The packing was removed and a couple of bleeding points were secured with difficulty. The hemorrhage was an oozing from broad surfaces, not from pumping vessels, and the difficulty was due to the contraction of the parts caused by the styptic cotton. She was put to bed in a collapsed condition and never rallied. This was our first case in the hospital and our first and only death for the year, and my first death following this operation. It taught me a useful lesson. Never hurry a patient off the table after such an operation on the cervix, trusting to iron and firm packing to prevent hemorrhage. Take time to see that every bleeding point is secured, and it takes time to make sure of this. Sometimes this cannot be done by pressure, by sponge or forceps, but vessels have to be tied. This cannot be done in the usual way by ligature, as sufficient tissue to hold the ligature is not afforded by the dense surface. I use my needle forceps, which was invented for trachelorrhaphy, and by passing the needle from the vaginal surface inward toward the uterine excavation I thread it, and on withdrawing it have a large amount of tissue embraced within the ligature. This sloughs off as the result of packing with zinc chloride.

Case 2 was in a very young woman, 38 years, and although the repair of the uterine excavation after the separation of the slough was fairly prompt, yet her nutrition was never restored, and she died from exhaustion in a few weeks after her return home.

Case 3 was also a young woman at 40. She lived several months with no return of the disease in the pelvis, but she ate less and less, and gradually wasted, dying exhausted in six months.

The fact that it is impossible to arrest epithelioma of the uterine cervix in women before the menopause has led me to divide these subjects into two classes. In women with the tissue changes confined to the cervix after this period the rule is for the cure to be permanent or the disease not to return for many months or years. This has led me to keep within the safe limits of a conservative operation, and not subject the young woman to the extreme hazard of total uterine extirpation.

A remarkable instance of female masturbation was admitted to

the hospital. She was 65 years old, married, with several children. She was admitted as a case of pruritus of the vulva. No suspicion was entertained of a refined and distinguished appearing old lady of prominent family and fifteen years past the climacteric. The clitoris was covered with greatly thickened integument, and as large as the penis of a child; the glans was buried deeply in indurated corrugations of whitish integument. The labia minora, indurated and deeply fissured, projected nearly two inches beyond the vulvar commissure. She was mentally morbid, appetite uncertain and physically weak. About two weeks after her admission Miss Dr. Adams, the house surgeon, told me that the nurses refused to make any further local applications, as the patient tried to force their fingers into her vulva, and would at the same time make lascivious motions with her body. Upon this I resolved to amputate the clitoris and nymphæ. This was done and the edges of the incisions brought together by catgut sutures. Upon the right and over the site of the extirpated clitoris several stiff wire sutures were placed, with their twisted ends projecting to prevent her fingering, on the plan of wiring a pig. The row of projecting wires looked formidable, but they proved useless, as on the fourth day the nurse discovered that she was bleeding freely, and an examination showed that she had torn the right nympha open. I lost patience with her and gave her a severe scolding in the presence of her daughter-in-law who was visiting her. My scolding was too much for the poor creature; she broke down and confessed the whole thing. A more humiliating confession I never heard. She began the practice in early girlhood, and continued it all through her married life. She would leave her husband's bed directly after sexual relations, go into the next room and masturbate. Her morning visit to the closet and while undressing at night were times at which her temptation came upon her with peculiar force, and were seldom passed without indulging. During all this time her health and strength continued unimpaired until after the menopause, which was at about fifty, when indulgence was followed by severe prostration. She stated that no change was noticed in the parts until after her fortieth year. We were obliged to put a nurse upon guard day and night until the parts were thoroughly healed. Some months after her return home a letter from a member of her family informed us

that she was greatly improved and had nearly given up the habit.

In a group of cases, suffering from what we have got in the habit of terming bedism, we have had very happy results. In the main these are cases which were originally taken down with acute sickness or functional pelvic trouble and through impaired will-power fail to get up. They become overdosed under the delusion that there is some "medicine" for their ills; add to this morbid sympathy and unhygienic surroundings, and we have an array of conditions that will defy the utmost skill. These cases are frequently termed neurasthemia or nerve exhaustion, and are subjected to enforced rest and milk cure. This, so far as our own cases is concerned, is a mistake. These are not cases of nerve-tire, but of will-tire, for which our term "bedism" is a fair equivalent. The first step toward cure is removal from their habitual environment. Then stop all medicine so that the patient's mind may be concentrated on the fact that relief must come from direct physical causes. Between Faradism, bathing, manipulations and palpations and passive limb movements, she is made to do a hard day's work and by night she is tired, as wholesome a sensation as that of hunger, and begins to sleep without her habitual anodyne. Without attracting her attention to the fact she is made to do things which she would have believed impossible, without being made any the worse by it. She has had a very comfortable time of it up to this point, but now her attention is called to the fact that she is really doing a fair day's work, and is all the better for it. She is now taught to walk, not teazed into it, but by some excuse like walking to the bath-room, because she can be treated more thoroughly. Directly she does this, the fact is impressed upon her in full force that she is able to walk, and is made the better by it. Thus step by step her education is carried on until we leave her on the street walking, never driving. There are not two cases, of course, treated alike, but this is a fair outline of the course usually pursued. I give this reference to the few cases we have had of this character, simply to demonstrate that the fashionable treatment by enforced rest and feeding is not the only if even so prompt a method of treating these difficult cases.

The laparotomies made fall into our second year, and will be mentioned in our next report.

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For admission, address

Dr. F. A. ADAMS, *House Surgeon*,

OR

Dr. ELY VAN DE WARKER.